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**OKLAHOMA DEPARTMENT OF CORRECTIONS
EMERGENCY PRESCRIPTION REQUEST**

Facility Name: _____ Date: _____ Time: _____

Person Completing Form: _____
Signature _____ Printed Name _____

Complete ALL sections legibly and sign where indicated. Incomplete fields may delay the processing of this order.

- | | |
|---|-------|
| 1. Have you verified that the medications are not available in a stat box or as stock? | Y / N |
| 2. Are all of these medications deemed necessary by the prescriber to be started immediately? | Y / N |
| 3. Are all medications ordered on the formulary for your facility? | Y / N |
| 4. If medication is non-formulary, has it been approved? | Y / N |

** Please note that Scheduled II controlled drugs cannot be filled locally unless a DEA licensed prescriber manually signs a written prescription that can be given to the dispensing pharmacy at the time of dispensing. Schedule II prescriptions must be filled for the quantity written.*

Rx Name: _____ Last First
Allergies: _____
Prescriber: _____
DEA#: _____
Amount to be filled by back-up Pharmacy: _____ *
Amount to be filled by PharmaCorr: _____ *

Rx Name: _____ Last First
Allergies: _____
Prescriber: _____
DEA#: _____
Amount to be filled by back-up Pharmacy: _____ *
Amount to be filled by PharmaCorr: _____ *

To Transmit a prescription claim, please use the following information:

EHO Rx Processing Information

Processor: EHO (Employer Health Options)

BIN #'s: NDC = 004527 or 004880

Condor Code: 15721

Envoy/Emdeon = 003241

Version: 5.1

Pharmacist HelpDesk: Phone: (800) 650-1817 or (254) 771-6000

Fax: (254) 774-8155

E-Mail: eho@drugbenefit.com

PharmaCorr Inmate Information:		
Last Name: _____	Offender ID#: _____	Group: 28010
First Name: _____	Date of Birth: _____	Sex: M / F
Prior Authorization #: _____		
(Note: The Prior Authorization number is the 4 digit Cost Center Code.)		

Fax to the toll free PHARMACY BACKUP HOTLINE 1.888.337.1887.

DO NOT fax with your REGULAR ORDERS, this will delay the process.